



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

SPINE HOSPITAL OF SOUTH TEXAS  
18600 N HARDY OAK BLVD  
SAN ANTONIO TX 78258

#### **Respondent Name**

ARROWOOD INDEMNITY CO

#### **Carrier's Austin Representative Box**

Box Number: 11

#### **MFDR Tracking Number**

M4-05-1777-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "To reduce payment for medical services with no maximum allowable reimbursement, Texas Administrative Code Section 133.304 provides that the 'insurance carrier shall: (5) Develop and consistently apply a methodology to determine a fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances received similar reimbursement; (6) Explain and document the method it used to calculate the rate of pay, and apply this method consistently; (7) Reference its method in the claim file; and (8) Explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement.' Emphasis added. In this instance, the Carrier did not provide any documentation of a developed or consistently applied methodology, which was used in reducing payment for the treatment/service in question. The healthcare provider charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. Based upon the requirements of Texas Administrative Code Section 130.304, a methodology may be developed to establish that a 'fair and reasonable' reimbursement amounts to ensure proper payment by Workers' Compensation Carriers. The methodology utilized by the healthcare provider was created to ensure that similar procedures provided in similar circumstances received similar reimbursement from Carriers."

**Amount in Dispute:** \$18,395.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The Insurance Carrier, or its agent, did not respond to the request for medical fee dispute resolution.

### **SUMMARY OF FINDINGS**

| Date(s) of Service | Disputed Services  | Amount In Dispute | Amount Due |
|--------------------|--------------------|-------------------|------------|
| July 9, 2004       | Outpatient Surgery | \$18,395.00       | \$0.00     |

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 4, 2004. According to the requestors position summary, "The Healthcare Provider received correspondence from the Commission via facsimile requesting additional documentation on 10/20/2004." Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the requestor submitted additional information November 17, 2004 and August 31, 2007. The additional information was submitted to the insurance carrier.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - M – Allowance for this procedure was made at the "Fair and Reasonable" amount for this geographical area.
  - Reconsideration complete. In reference to payment #68053511 issued 8/10/04 in the amount of \$2236.00 No Additional amount due. A denial letter will follow.

### **Findings**

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
4. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
5. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
6. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "The methodology utilized by the healthcare provider was created to ensure that similar procedures provided in similar circumstances receive similar reimbursement from Carriers."
- The requestor submitted a procedure analysis showing payments from other carriers to support same or similar services to support the methodology the healthcare provider utilized.
- The requestor does not discuss or explain how their methodology supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

February 16, 2012  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**